

		FOR OHF USE					

LL 1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0046169</u></p> <p>Facility Name: <u>Lakewood Nursing & Rehab Center, Llc</u></p> <p>Address: <u>1112 North Eastern Avenue</u> <u>Plainfield</u> <u>60544</u> Number City Zip Code</p> <p>County: <u>Will</u></p> <p>Telephone Number: <u>(815) 436-3400</u> Fax # <u>(815) 436-1357</u></p> <p>IDPA ID Number: <u>300124869001</u></p> <p>Date of Initial License for Current Owners: <u>02/01/03</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td></td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Print Name and Title) <u>Edward N. Slack, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p style="text-align: center;">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____		(Signed) _____ (Date) _____	Paid Preparer	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																													
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																													
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																													
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																													
	<input type="checkbox"/> "Sub-S" Corp.																														
	<input checked="" type="checkbox"/> Limited Liability Co.																														
	<input type="checkbox"/> Trust																														
	<input type="checkbox"/> Other _____																														
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____																														
	(Signed) _____ (Date) _____																														
Paid Preparer	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																														

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>93</u>	Skilled (SNF)	<u>93</u>	<u>34,038</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>93</u>	TOTALS	<u>93</u>	<u>34,038</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,083</u>	<u>14,377</u>	<u>5,395</u>	<u>32,855</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,083</u>	<u>14,377</u>	<u>5,395</u>	<u>32,855</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.52%

D. How many bed-hold days during this year were paid by Public Aid?

6 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/1/03

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/1/03 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 93 and days of care provided 5,080Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	198,304	18,737	10,929	227,970		227,970	1,196	229,166			1
2	Food Purchase		159,673		159,673		159,673	659	160,332			2
3	Housekeeping	98,927	22,639		121,566		121,566	(4,510)	117,056			3
4	Laundry	43,433	22,939		66,372		66,372	(1,822)	64,550			4
5	Heat and Other Utilities			95,126	95,126		95,126	821	95,947			5
6	Maintenance	70,687	36	77,520	148,243		148,243	(15,550)	132,693			6
7	Other (specify):*							1,115	1,115			7
8	TOTAL General Services	411,351	224,024	183,575	818,950		818,950	(18,090)	800,860			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,775,552	120,787	21,420	1,917,759		1,917,759	(12,167)	1,905,592			10
10a	Therapy	135,792		1,360	137,152		137,152		137,152			10a
11	Activities	83,195	9,212	388	92,795		92,795		92,795			11
12	Social Services	93,582		2,761	96,343		96,343	5,906	102,249			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,136	3,136			15
16	TOTAL Health Care and Programs	2,088,121	129,999	40,329	2,258,449		2,258,449	(3,125)	2,255,324			16
	C. General Administration											
17	Administrative	83,216			83,216		83,216	7,556	90,772			17
18	Directors Fees											18
19	Professional Services			134,956	134,956		134,956	(86,750)	48,206			19
20	Dues, Fees, Subscriptions & Promotions			25,879	25,879		25,879	(8,774)	17,105			20
21	Clerical & General Office Expenses	47,844	17,490	96,692	162,026		162,026	24,040	186,066			21
22	Employee Benefits & Payroll Taxes			445,662	445,662		445,662	(5,466)	440,196			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,068	1,068		1,068	2,223	3,291			24
25	Other Admin. Staff Transportation			3,177	3,177		3,177		3,177			25
26	Insurance-Prop.Liab.Malpractice			91,831	91,831		91,831	482	92,313			26
27	Other (specify):*							13,620	13,620			27
28	TOTAL General Administration	131,060	17,490	799,265	947,815		947,815	(53,069)	894,746			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,630,532	371,513	1,023,169	4,025,214		4,025,214	(74,284)	3,950,930			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc #0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			23,150	23,150		23,150	70,379	93,529			30
31	Amortization of Pre-Op. & Org.							9,786	9,786			31
32	Interest			1	1		1	89,964	89,965			32
33	Real Estate Taxes			42,189	42,189		42,189	1,015	43,204			33
34	Rent-Facility & Grounds			271,560	271,560		271,560	(268,796)	2,764			34
35	Rent-Equipment & Vehicles			10,922	10,922		10,922	989	11,911			35
36	Other (specify):*											36
37	TOTAL Ownership			347,822	347,822		347,822	(96,663)	251,159			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		280,328	442,467	722,795		722,795	(11,594)	711,201			39
40	Barber and Beauty Shops			26,256	26,256		26,256	(26,256)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,156	52,156		52,156	(1,099)	51,057			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		280,328	520,879	801,207		801,207	(38,949)	762,258			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,630,532	651,841	1,891,870	5,174,243		5,174,243	(209,896)	4,964,347			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 01/01/04

Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals			4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation	(33,375)	30	9
10	Interest and Other Investment Income	(29,885)	32	10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax	(699)	02	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions			20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt	(55,800)	21	24
25	Fund Raising, Advertising and Promotional	(10,309)	20	25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule	(72,020)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (202,088)		30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	(7,809)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (7,809)	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (209,896)	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
Lakewood Nursing & Rehab Center, LLC		
ID# 0044105		
Report Period Beginning:	01/01/04	
Ending:	12/31/04	
NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1 Other Income	\$(830)	21 1
2 Duty Duty Income	(26)	19 2
3 Patient Clothing	(1,361)	19 3
4 Barber & Beauty	(26,256)	40 4
5 Collection Expenses	(67)	21 5
6 Excises And Tax	(1,099)	42 6
7 Building Company - Bank Charges	(386)	21 7
8 Building Company - Filing Fees	(259)	21 8
9 Prior Year - Legal Fees	(1,159)	19 9
10 Duplicated Legal Fees	(400)	19 10
11 Amortization - Goodwill	(12,994)	21 11
12 Capitalized R&M	(19,343)	86 12
13 Nurses Aide Salary write off per equity stmt	(7,765)	19 13
14		14
15		15
16		16
17		17
18		18
19		19
20		20
21		21
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29		29
30		30
31		31
32		32
33		33
34		34
35		35
36		36
37		37
38		38
39		39
40		40
41		41
42		42
43		43
44		44
45		45
46		46
47		47
48		48
49		49
50		50
51		51
52		52
53		53
54		54
55		55
56		56
57		57
58		58
59		59
60		60
61		61
62		62
63		63
64		64
65		65
66		66
67		67
68		68
69		69
70		70
71		71
72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90		90
91		91
92		92
93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101 Total	(72,020)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning:

01/01/04

Ending:

12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(45)	215		1,961	(935)				1,196	1
2	Food Purchase	(699)							1,358				659	2
3	Housekeeping				(4,510)								(4,510)	3
4	Laundry				(1,822)								(1,822)	4
5	Heat and Other Utilities					821							821	5
6	Maintenance	(19,343)			(24)	877		2,925	15				(15,550)	6
7	Other (specify):*						200	715	200				1,115	7
8	TOTAL General Services	(20,042)			(6,401)	1,913	200	5,601	638				(18,090)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(9,146)			(13,243)			10,222					(12,167)	10
10a	Therapy													10a
11	Activities													11
12	Social Services							5,906					5,906	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						777	2,359					3,136	15
16	TOTAL Health Care and Programs	(9,146)			(13,243)		777	18,487					(3,125)	16
	C. General Administration													
17	Administrative							7,458	98				7,556	17
18	Directors Fees													18
19	Professional Services	(1,649)				(85,111)			10				(86,750)	19
20	Fees, Subscriptions & Promotions	(10,309)				1,530			5				(8,774)	20
21	Clerical & General Office Expenses	(57,333)	636			8,009		72,551	177				24,040	21
22	Employee Benefits & Payroll Taxes			(1,467)	(935)		(3,064)						(5,466)	22
23	Inservice Training & Education													23
24	Travel and Seminar					2,179			44				2,223	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					444			38				482	26
27	Other (specify):*						2,011	11,609					13,620	27
28	TOTAL General Administration	(69,291)	636	(1,467)	(935)	(72,949)	(1,053)	91,618	372				(53,069)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(98,479)	636	(1,467)	(20,579)	(71,036)	(76)	115,706	1,010				(74,284)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(33,375)	94,276			8,142				1,336			70,379	30
31	Amortization of Pre-Op. & Org.	(12,994)	22,780										9,786	31
32	Interest	(29,885)	119,694						6	149			89,964	32
33	Real Estate Taxes					1,015							1,015	33
34	Rent-Facility & Grounds		(271,560)			2,560			204				(268,796)	34
35	Rent-Equipment & Vehicles					985			4				989	35
36	Other (specify):*													36
37	TOTAL Ownership	(76,254)	(34,810)			12,702			214	1,485			(96,663)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(5,838)				(2,991)	(2,765)			(11,594)	39
40	Barber and Beauty Shops	(26,256)											(26,256)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(1,099)											(1,099)	42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(27,355)			(5,838)				(2,991)	(2,765)			(38,949)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(202,088)	(34,174)	(1,467)	(26,417)	(58,334)	(76)	115,706	(1,767)	(1,280)			(209,896)	45

STATE OF ILLINOIS

Page 6

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169

Report Period Beginning:

01/01/04

Ending:

12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Lakewood Plainfield Property LLC		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 271,560	Lakewood Plainfield Property LLC		\$	(271,560)	1
2	V	21 Bank Charges				386	386	2
3	V	21 Filing Fees				250	250	3
4	V	31 Amortization				22,780	22,780	4
5	V	32 Interest Expense				119,694	119,694	5
6	V	30 Depreciation				94,276	94,276	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 271,560			\$ 237,386	\$ * (34,174)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 270,110	\$ 270,110	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	271,577	CCS EMPLOYEE BENEFIT GROUP	100.00%		(271,577)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 271,577			\$ 270,110	\$ * (1,467)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 DIETARY	\$ 302	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 257	\$ (45)	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03 HOUSEKEEPING	30,397	XCEL MEDICAL SUPPLY, LLC	100.00%	25,887	(4,510)	17
18	V	04 LAUNDRY	12,284	XCEL MEDICAL SUPPLY, LLC	100.00%	10,462	(1,822)	18
19	V	06 REPAIRS & MAINTENANCE	159	XCEL MEDICAL SUPPLY, LLC	100.00%	135	(24)	19
20	V	10 NURSING	89,264	XCEL MEDICAL SUPPLY, LLC	100.00%	76,021	(13,243)	20
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS	6,300	XCEL MEDICAL SUPPLY, LLC	100.00%	5,365	(935)	24
25	V	39 ANCILLARY	39,352	XCEL MEDICAL SUPPLY, LLC	100.00%	33,514	(5,838)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 178,058			\$ 151,641	\$ * (26,417)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 215	\$ 215
16	V	05 Utilities		Care Centers, Inc.	100.00%	821	821
17	V	06 Maintenance		Care Centers, Inc.	100.00%	877	877
18	V	10 Nursing		Care Centers, Inc.	100.00%		
19	V	11 Activities		Care Centers, Inc.	100.00%		
20	V	19 Professional Fees	89,532	Care Centers, Inc.	100.00%	4,421	(85,111)
21	V	20 Dues and Subscriptions		Care Centers, Inc.	100.00%	1,530	1,530
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	8,009	8,009
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	2,179	2,179
24	V	26 Insurance		Care Centers, Inc.	100.00%	444	444
25	V	30 Depreciation		Care Centers, Inc.	100.00%	8,142	8,142
26	V	32 Interest		Care Centers, Inc.	100.00%		
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	1,015	1,015
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	2,560	2,560
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	985	985
30	V	25 Bus Reimbursement		Care Centers, Inc.	100.00%		
31	V	02 Food		Care Centers, Inc.	100.00%		
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 89,532			\$ 31,198	\$ * (58,334)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	06 Maintenance Salary	\$ 1,364	Care Centers, Inc.	100.00%	\$ 1,364	\$
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	200	200
17	V	10 Nursing Salary	2,209	Care Centers, Inc.	100.00%	2,209	
18	V	10a Rehab Salary	1,360	Care Centers, Inc.	100.00%	1,360	
19	V	11 Activity Salary		Care Centers, Inc.	100.00%		
20	V	12 Social Service Salary	1,744	Care Centers, Inc.	100.00%	1,744	
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	777	777
22	V	17 Administration Salary		Care Centers, Inc.	100.00%		
23	V	21 Office Salary	13,747	Care Centers, Inc.	100.00%	13,747	
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	2,011	2,011
25	V	22 Employee Benefits	3,064	Care Centers, Inc.	100.00%		(3,064)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 23,488			\$ 23,412	\$ * (76)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01 Dietary Salary	\$	Care Centers, Inc.	100.00%	\$ 1,961	\$ 1,961	15
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	2,925	2,925	17
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	715	715	18
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	10,222	10,222	19
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	5,906	5,906	21
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	2,359	2,359	22
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	7,458	7,458	23
24	V	21 Office Salary		Care Centers, Inc.	100.00%	72,551	72,551	24
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	11,609	11,609	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 115,706	\$ * 115,706	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 01/01/04

Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$ 2,683	Care Centers, Inc. - Health Systems Division	100.00%	\$ 380	\$ (2,303)
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	1,358	1,358
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	15	15
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	98	98
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	10	10
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	5	5
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	177	177
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	44	44
23	V	26 Insurance		Care Centers, Inc. - Health Systems Division	100.00%	38	38
24	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	6	6
25	V	34 Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	204	204
26	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	4	4
27	V	39 Ancillary Enteral Supplies	6,056	Care Centers, Inc. - Health Systems Division	100.00%	3,065	(2,991)
28	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,368	1,368
29	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	200	200
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 8,739			\$ 6,972	\$ * (1,767)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Vent Lease, LLC.	100.00%	\$ 1,336	\$ 1,336	15
16	V	32 Interest		Vent Lease, LLC.	100.00%	149	149	16
17	V	39 Vent Reimbursement	2,765	Vent Lease, LLC.	100.00%		(2,765)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 2,765			\$ 1,485	\$ * (1,280)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning: 01/01/04Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Lakewood Nursing & Rehab Center, LLC # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.00%	See Attached	0.69	1.50%		\$		1
2	Adam Vales	Owner	Clerical	11.00%	See Attached	1.76	4.40%	Alloc Salary	1,822	22-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	1.00	1.82%	Alloc Salary	1,338	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,160		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 2201 WEST MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 270,110	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 270,110	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
 Street Address 2201 WEST MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 DIETARY	Direct Allocation			\$	\$		\$ 257	1
2	02 FOOD	Direct Allocation							2
3	03 HOUSEKEEPING	Direct Allocation						25,887	3
4	04 LAUNDRY	Direct Allocation						10,462	4
5	06 REPAIRS & MAINTENANCE	Direct Allocation						135	5
6	10 NURSING	Direct Allocation						76,021	6
7	10A THERAPY	Direct Allocation							7
8	12 SOCIAL SERVICE	Direct Allocation							8
9	21 CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22 EMPLOYEE BENEFITS	Direct Allocation						5,365	10
11	39 ANCILLARY	Direct Allocation						33,514	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 151,641	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Patient Days	1,484,397	42	\$ 9,730	\$	32,855	\$ 215	1
2	05 Utilities	Patient Days	1,484,397	42	37,103		32,855	821	2
3	06 Maintenance	Patient Days	1,484,397	42	39,622		32,855	877	3
4	10 Nursing	Patient Days	1,484,397	42			32,855		4
5	11 Activities	Patient Days	1,484,397	42			32,855		5
6	19 Professional Fees	Patient Days	1,484,397	42	199,755		32,855	4,421	6
7	20 Dues and Subscriptions	Patient Days	1,484,397	42	69,116		32,855	1,530	7
8	21 Office & Clerical	Patient Days	1,484,397	42	361,868		32,855	8,009	8
9	24 Travel and Seminar	Patient Days	1,484,397	42	98,454		32,855	2,179	9
10	26 Insurance	Patient Days	1,484,397	42	20,081		32,855	444	10
11	30 Depreciation	Patient Days	1,484,397	42	367,842		32,855	8,142	11
12	32 Interest	Patient Days	1,484,397	42			32,855		12
13	33 Real Estate Taxes	Patient Days	1,484,397	42	45,838		32,855	1,015	13
14	34 Rent - Building	Patient Days	1,484,397	42	115,677		32,855	2,560	14
15	35 Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		32,855	985	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,409,572	\$		\$ 31,198	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06 Maintenance Salary	Direct Cost			264,919	264,919		1,364	1
2	07 Emp. Ben. - Gen. Serv.	Direct Cost			38,757			200	2
3	10 Nursing Salary	Direct Cost			209,584	209,584		2,209	3
4	10a Rehab Salary	Direct Cost			66,982	66,982		1,360	4
5	11 Activity Salary	Direct Cost							5
6	12 Social Service Salary	Direct Cost			66,710	66,710		1,744	6
7	15 Emp. Ben. - Healthcare	Direct Cost			50,220			777	7
8	17 Administration Salary	Direct Cost			38,431	38,431			8
9	21 Office Salary	Direct Cost			525,935	525,935		13,747	9
10	27 Emp. Ben. - Gen. Admin.	Direct Cost			82,566			2,011	10
11	22 Employee Benefits								11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,344,103	\$ 1,172,560		\$ 23,412	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	32,855	1,961	1
2	03 Housekeeping Salary	Patient Days	1,484,397	42			32,855		2
3	06 Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	32,855	2,925	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		32,855	715	4
5	10 Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	32,855	10,222	5
6	10a Rehab Salary	Patient Days	1,484,397	42			32,855		6
7	12 Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	32,855	5,906	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		32,855	2,359	8
9	17 Administration Salary	Patient Days	1,484,397	42	336,976	336,976	32,855	7,458	9
10	21 Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	32,855	72,551	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		32,855	11,609	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,227,610	\$ 4,564,232		\$ 115,706	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Billable Income	2,144,835		93,149		8,739	380	1
2	02 Food	Billable Income	2,144,835		987,169		8,739	1,358	2
3	06 Maintenance	Billable Income	2,144,835		3,597		8,739	15	3
4	17 Administration	Billable Income	2,144,835		24,000		8,739	98	4
5	19 Professional Fees	Billable Income	2,144,835		2,500		8,739	10	5
6	20 Dues & Subscriptions	Billable Income	2,144,835		1,342		8,739	5	6
7	21 Office & Clerical	Billable Income	2,144,835		43,384		8,739	177	7
8	24 Travel & Seminar	Billable Income	2,144,835		10,755		8,739	44	8
9	26 Insurance	Billable Income	2,144,835		9,262		8,739	38	9
10	32 Interest Expense	Billable Income	2,144,835		1,371		8,739	6	10
11	34 Rent - Building	Billable Income	2,144,835		50,000		8,739	204	11
12	35 Rent - Equipment & Auto	Billable Income	2,144,835		1,080		8,739	4	12
13	39 Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		8,739	3,065	13
14	01 Dietary - Salary	Billable Income	2,144,835		335,801	335,801	8,739	1,368	14
15	07 Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		8,739	200	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,711,055	\$ 335,801		\$ 6,972	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30 Depreciation	Direct Billing	620,670	29	\$ 300,000	\$	2,765	\$ 1,336	1
2	32 Interest	Direct Billing	620,670	29	33,493		2,765	149	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 333,493	\$		\$ 1,485	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc # 0046169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LaSalle Bank		X	Mortgage			\$		\$ 2,418,414			\$ 110,080	1
2	Genesis		X						160,232			9,614	2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Alloc from Care Centers											6	6
7	Alloc from Vent Lease											149	7
8	See Supplemental Schedule												8
9	TOTAL Facility Related						\$		\$ 2,578,646			\$ 119,849	9
	B. Non-Facility Related*												
10	Interest Income											(29,885)	10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$		\$			\$ (29,885)	14
15	TOTALS (line 9+line14)						\$		\$ 2,578,646			\$ 89,964	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Lakewood Nursing & Rehab Center, LLC**# **0046169**

Report Period Beginning:

01/01/04

Ending:

12/31/04**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.		\$ 47,813	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 44,918	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (2,895)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 46,099	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 43,204	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999 49,663	8	
	2000 51,450	9	
	2001 52,662	10	
	2002 45,196	11	
	2003 43,903	12	
2004 Accrual = 2003 Tax \$43,903 x 1.05 = \$46,099			
Care Centers Inc allocation \$1015			

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>06-03-10-312-003-0000</u>	<u>Long Term Care Property</u>	\$ <u>43,903.26</u>	\$ <u>43,903.26</u>
2. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>106,873.39</u>	\$ <u>1,015.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>150,776.65</u></u>	\$ <u><u>44,918.26</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lakewood Nursing & Rehab Center, Llc COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046169

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
 15,925
 B. General Construction Type:
 Exterior
 Brick
 Frame
 Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 49,405
 2. Number of Years Over Which it is Being Amortized:
 various

3. Current Period Amortization:
 9,786
 4. Dates Incurred:
 2003, 2004

Nature of Costs:
 Loan Closing Costs, Letter of Intent, Esc & Deposits, LLC & Articles, Purchase Agreement

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	273,121	2003	\$ 237,379	1
2	2201 Main LLC allocation			7,784	2
3	TOTALS	273,121		\$ 245,163	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10								-		-	9
11								-		-	10
12								-		-	11
13								-		-	12
14								-		-	13
15								-		-	14
16								-		-	15
17								-		-	16
18								-		-	17
19								-		-	18
20								-		-	19
21								-		-	20
22								-		-	21
23								-		-	22
24								-		-	23
25								-		-	24
26								-		-	25
27								-		-	26
28								-		-	27
29								-		-	28
30								-		-	29
31								-		-	30
32								-		-	31
33								-		-	32
34								-		-	33
35								-		-	34
36								-		-	35

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,099,630	53,837		53,837		100,944	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		30,031	1,233		1,233		2,561	68
69	Financial Statement Depreciation			15,985			(15,985)		69
70	TOTAL (lines 4 thru 69)		\$ 2,129,661	\$ 71,055		\$ 55,070	\$ (15,985)	\$ 103,505	70

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,129,661	\$ 71,055		\$ 55,070	\$ (15,985)	\$ 103,505	1
2	Water Heater	2003	4,980		20	380	380	726	2
3	Roof Repairs	2003	750		20	34	34	59	3
4	Tile Repair	2003	1,012		20	62	62	107	4
5	Security System	2003	2,803		20	367	367	601	5
6	Hot Water Heater	2003	4,719		20	360	360	590	6
7	A/C Repair	2003	760		20	58	58	84	7
8	Hot Water Repair	2003	786		20	60	60	87	8
9	Hot Water Repair	2003	2,632		20	201	201	292	9
10	Plumbing Repair	2003	1,650		20	76	76	103	10
11	Fire Alarm Control Panel Repair	2003	557		20	73	73	99	11
12	Water Heater	2004	3,295		20	229	229	252	12
13	Hot Water System	2004	1,270		20	21	21	21	13
14	Water Heater	2004	908		20	15	15	15	14
15	Smoke Dampers	2004	1,082		20	18	18	18	15
16	Compressor	2004	5,987		20	100	100	100	16
17	Generator	2004	1,181		20	56	56	56	17
18	Wall Heater	2004	818		20	11	11	11	18
19	Engineering Fees	2004	2,350		20	20	20	20	19
20	Nurse Call System-Call Cords	2004	607		20	30	30	30	20
21	Roof Repairs	2004	750		20	28	28	28	21
22	Alarm - Transmitter	2004	516		20	19	19	19	22
23	Alarm - Controller / Receiver	2004	1,215		20	46	46	46	23
24	Overbed Lights	2004	656		20	22	22	22	24
25	Alarm Repairs	2004	557		20	19	19	19	25
26	Cubicle Curtains	2004	1,738		20	58	58	58	26
27	A/C Repair	2004	688		20	23	23	23	27
28	A/C Repair	2004	611		20	18	18	18	28
29	Roof Work	2004	1,665		20	49	49	49	29
30	Alarms	2004	763		20	22	22	22	30
31	Hot Water System Repiar	2004	1,113		20	23	23	23	31
32	A/C Repair	2004	1,188		20	25	25	25	32
33	A/C Repair	2004	1,031		20	17	17	17	33
34	TOTAL (lines 1 thru 33)		\$ 2,180,299	\$ 71,055		\$ 57,610	\$ (13,445)	\$ 107,145	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 2,180,299	\$ 71,055		\$ 57,610	\$ (13,445)	\$ 107,145	1
2	Exhaust System	2004	772		20	13	13	13	2
3	Make Up Air-Out Kitchen	2004	512		20	6	6	6	3
4	Hvac Work	2004	1,060		20	13	13	13	4
5	New Locks	2004	729		20	9	9	9	5
6	Heating Repairs	2004	1,245		20	16	16	16	6
7	Wall Unit - Circuit Boards	2004	838		20	7	7	7	7
8	Repair Kitchen Door Closer	2004	530		20	4	4	4	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	34

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward	\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	34

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12G, Carried Forward	\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213		1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213		34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward	\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	34

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	34

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,185,985	\$ 71,055		\$ 57,678	\$ (13,377)	\$ 107,213	34

XI. OWNERSHIP COSTS (continued)										
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.										
	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation
4	93		2003		\$ 2,099,630	\$ 53,837	39	\$ 53,837	\$	\$ 100,944
5										
6										
7										
8										
9	Improvement Type**									
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,099,630	\$ 53,837		\$ 53,837	\$	\$ 100,944	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	2201 Main LLC			2002	\$ 10,727	\$ 268	40	\$ 268		\$ 670	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	8,861	443	20	443		1,108	9
10	Allocation - 2201 Main LLC			2003	10,443	522	20	522		783	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 30,031	\$ 1,233		\$ 1,233	\$	\$ 2,561	70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 180,870	\$ 49,942	\$ 30,471	\$ (19,471)	10	\$ 81,188	71
72	Current Year Purchases	38,369	4,771	4,244	(527)	10	4,244	72
73	Fully Depreciated Assets	7,225				10	7,225	73
74								74
75	TOTALS	\$ 226,464	\$ 54,713	\$ 34,715	\$ (19,998)		\$ 92,657	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Centers Allocation		\$ 15,349	\$ 1,134	\$ 1,134		5	\$ 1,134	76
77										77
78										78
79										79
80	TOTALS			\$ 15,349	\$ 1,134	\$ 1,134			\$ 1,134	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,672,961	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 126,902	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 93,527	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (33,375)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 201,004	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	C-I-P (Architect Fees)	\$ 207,649	92
93	C-I-P (IDPH)	11,000	93
94			94
95		\$ 218,649	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from Care Centers				2,764			5
6								6
7	TOTAL				\$ 2,764			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 11,911

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 72,843	\$		\$ 72,843	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			18,053			18,053	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			351,428			351,428	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				210,137		210,137	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					143	70,191		70,334	13
14	TOTAL			\$		\$ 442,467	\$ 280,328		\$ 722,795	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,197	\$ 38,081	1
2	Cash-Patient Deposits	5,420	5,420	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,158,211	1,158,211	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,456	11,456	6
7	Other Prepaid Expenses	8,096	8,096	7
8	Accounts Receivable (owners or related parties)	342,182		8
9	Other(specify): See Attached Schedule	780,584	883,133	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,315,146	\$ 2,104,397	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,379	13
14	Buildings, at Historical Cost		2,606,387	14
15	Leasehold Improvements, at Historical Cost	55,070	55,070	15
16	Equipment, at Historical Cost	68,285	192,078	16
17	Accumulated Depreciation (book methods)	(33,178)	(221,620)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		49,406	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(19,233)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		228,649	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 90,177	\$ 3,128,116	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,405,323	\$ 5,232,513	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 526,335	\$ 526,335	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,289	5,289	28
29	Short-Term Notes Payable		160,232	29
30	Accrued Salaries Payable	161,565	161,565	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,858	11,858	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,099	46,099	32
33	Accrued Interest Payable		6,516	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	330,709	488,433	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,081,855	\$ 1,406,327	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,418,414	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 2,418,414	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,081,855	\$ 3,824,741	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,323,468	\$ 1,407,772	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,405,323	\$ 5,232,513	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 648,815	1
2	Restatements (describe):		2
3	<u>See Attached</u>	8,627	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 657,442	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	673,342	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(107,174)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>Additional Paid in Capital</u>	99,858	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 666,026	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,323,468	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 01/01/04

Ending:

12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,483,090	1
2	Discounts and Allowances for all Levels	(1,627,373)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,855,717	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,549,176	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,549,176	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	26,192	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	200,529	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,135	19
20	Radiology and X-Ray	6,050	20
21	Other Medical Services	137,055	21
22	Laundry	9,996	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 411,957	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29,885	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,885	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	850	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 850	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,847,585	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	818,950	31
32	Health Care	2,258,449	32
33	General Administration	947,815	33
	B. Capital Expense		
34	Ownership	347,822	34
	C. Ancillary Expense		
35	Special Cost Centers	749,051	35
36	Provider Participation Fee	52,156	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,174,243	40
41	Income before Income Taxes (line 30 minus line 40)**	673,342	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 673,342	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc# 0046169Report Period Beginning: 01/01/04Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,961	2,177	\$ 68,881	\$ 31.64	1
2	Assistant Director of Nursing	1,493	1,602	42,172	26.32	2
3	Registered Nurses	14,244	15,777	398,026	25.23	3
4	Licensed Practical Nurses	20,068	22,007	482,874	21.94	4
5	Nurse Aides & Orderlies	59,914	65,746	755,585	11.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,217	8,207	135,792	16.55	8
9	Activity Director	1,853	2,110	42,185	19.99	9
10	Activity Assistants	5,168	5,288	41,010	7.76	10
11	Social Service Workers	5,070	5,490	93,582	17.05	11
12	Dietician					12
13	Food Service Supervisor	2,065	2,271	41,693	18.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,250	16,669	156,611	9.40	15
16	Dishwashers					16
17	Maintenance Workers	4,253	4,785	70,687	14.77	17
18	Housekeepers	11,598	12,801	98,927	7.73	18
19	Laundry	4,618	5,188	43,433	8.37	19
20	Administrator	1,917	2,228	82,447	37.00	20
21	Assistant Administrator	62	35	769	21.97	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,577	6,150	47,844	7.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,825	1,843	28,014	15.20	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	164,153	180,374	\$ 2,630,532 *	\$ 14.58	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	251	\$ 10,929	01-03	35
36	Medical Director	monthly	14,400	09-03	36
37	Medical Records Consultant	monthly	4,136	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,069	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	388	11-03	44
45	Social Service Consultant	312	1,017	12-03	45
46	Other(specify)				46
47	<u>Dental Consultant</u>		1,045	10-03	47
48	<u>CCI - see attached</u>		5,311	various	48
49	TOTAL (lines 35 - 48)	571	\$ 40,295		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	178	\$ 8,283	10-03	50
51	Licensed Practical Nurses	77	2,678	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	255	\$ 10,961		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lakewood Nursing & Rehab Center, Llc

0046169

Report Period Beginning: 01/01/04

Ending: 12/31/04

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,786 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,057
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT